

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06111

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If one day is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
St. Marys MARYLAND		a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Potomac River		X Piney Point	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
		Stewart Oil Company	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX		4. DATE OF DEATH	
male		First Arthur Middle Aaron Buckner Last	
6. COLOR OR RACE		4. DATE OF DEATH	
white		April 26 1958	
7. MARRIED		5. SEX	
X NEVER MARRIED <input type="checkbox"/>		6. COLOR OR RACE	
WIDOWED <input type="checkbox"/>		7. MARRIED	
DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday)	
Tug boat Capt.		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)	
Wm. M. Buckner		South Carolina	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		12. CITIZEN OF WHAT COUNTRY?	
no		USA	
16. SOCIAL SECURITY NO.		17. INFORMANT	
247-28-0085		Jeanette B. Thibadeau- Heningston, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address 10609 Concord St	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Drowning		immediate	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
deceased was in small out board motor boat which sank			
20c. TIME OF INJURY Month, Day, Year Hour a. m.		20d. INJURY OCCURRED	
3:15 P.M. 4/26 1958		While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
in Potomac River		20e. PLACE OF DEATH Home, farm, factory, street, office bldg., etc.	
off: Piney Point, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE		DATE SIGNED	
EXAMINER'S NAME (Type)		5/18/58	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Cremation		5/20/58	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) (State)	
Cedar Hill Crematory		Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
P.B. Robinson - Leonardtown, Md.		24b. REGISTRAR'S SIGNATURE	
		DATE MAY 28 '58	
VS. A15ME(5) 5M 9/55			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #8-Film G228 - 4/29/58-mb  
4975 CERTIFICATE OF DEATH

04972

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Marys		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY St. Marys		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Great Mills				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Louis		First	Middle Theodore	Last Clarke	4. DATE OF DEATH Month 4	Day 17	Year 19 58	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 30, 1872 1871		9. AGE (In years last birthday) 86	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Clarke				14. MOTHER'S MAIDEN NAME Emily Burroughs				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Not in U.S.)		16. SOCIAL SECURITY NO.		17. INFORMANT Nettie M. Clarke		Address Great Mills Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO <i>Coronary sclerosis</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Generalized arterio sclerosis</i> ONSET AND DEATH 15 years								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Great Mills	(County) Md.	(State) Md.
21. I certify that I attended the deceased from <i>Dec 10, 1957</i> , to <i>April 17, 1958</i> , that I last saw the deceased alive on <i>April 16, 1958</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>P. J. Bean</i>								ADDRESS (Street, city or town, state) <i>Great Mills Md.</i>
PHYSICIAN'S NAME (Type) <i>P. J. Bean</i>								DATE SIGNED <i>4/17/58</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/19/58		22c. NAME OF CEMETERY OR CREMATORIAL Holy Face		22d. LOCATION (City, town, or county) Great Mills		
23. FUNERAL DIRECTOR'S SIGNATURE Robinson Funeral Home Leonardtown Md.								
ADDRESS <i>Leonardtown Md.</i>								
24a. REC'D BY REGISTRAR DATE APR 23 '58								
24b. REGISTRAR'S SIGNATURE <i>Albert L. Smith</i>								

## CERTIFICATE OF DEATH

BUREAU Y. S.  
RECEIVED

APR 23 1968

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4976 CERTIFICATE OF DEATH

Reg. Dist. No. 04973

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland		b. COUNTY		st Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		x Hollywood		d. STREET ADDRESS		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		st Mary's Hospital		d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Middle		4. DATE OF DEATH		Month		Day		Year	

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
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13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address			
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Failure of Development of Respiratory Center			
DUE TO		1 hour			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)			
DUE TO					
(c)					

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
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20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
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21. I certify that I attended the deceased from 4-7-58, 19, to 4-7-58, 19, that I last saw the deceased alive on 4-7-58, 19, and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
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ACTUAL SIGNATURE							
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PHYSICIAN'S NAME (Type)							
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22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
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23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
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Klaus H. Hartley		Leonardtown, Md		APR 9 '58		A. Leach	
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2078291 QB3

## BUREAU V.

APR 9 1958

PERGELIVE 30

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9, Film 6228, 4/28/58 fcy 1977

Reg. Dist. No. 04974

1. PLACE OF DEATH a. COUNTY St. Marys		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scotland		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scotland	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alexander		First	Middle Cullison
4. DATE OF DEATH	Month 4	Day 20	Year 58 19
5. SEX M	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Apr. 6 1910
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 4	11. IF UNDER 24 HRS. Days 49 Hours 49 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Cullison		14. MOTHER'S MAIDEN NAME Florence Handy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Isabelle Cullison		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 m</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Wm. B. Board</u>		DATE SIGNED <u>4/20/58</u>	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/58	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Lukes		22d. LOCATION (City, town, or county) Scotland	
23. FUNERAL DIRECTOR'S SIGNATURE Robinson Funeral Home Leonardtown Md.		24a. REC'D BY REGISTRAR APR 23 '58	
		24b. REGISTRAR'S SIGNATURE <u>W. J. Redick</u>	

WISCONSIN STATE GOVERNMENT OF MEXICO - AUTHORITY  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 23 1958

RECEIVED

## **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

4978

## **CERTIFICATE OF DEATH**

Reg. Dist. No.

04975

1. PLACE OF DEATH o. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New York Mass. b. COUNTY Duxbury, Mass.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River,		c. LENGTH OF STAY IN 1b 3 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California Swampscott 58x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Station Hospital, USNAS,		d. STREET ADDRESS 20 Beach Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edward		First "H"	Middle CUNNINGHAM	4. DATE OF DEATH April	Month Day Year 25 19 58		
5. SEX Male		6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 25 April 1958	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS. Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None - Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Melville Dexter Cunningham				14. MOTHER'S MAIDEN NAME Dorothy Heath			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT M. D. Cunningham, Address California, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> INTERVAL BETWEEN ONSET AND DEATH 3 hours 76.15 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Premature separation of low lying</u> (c) <u>placenta</u> DUE TO DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>25 April</u> , 19 <u>58</u> , to <u>25 April</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>25 April</u> , 19 <u>58</u> , and that death occurred at <u>7:15A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>J. E. Pyatte</u> M.D. Station Hospital, USNAS, 4-25-58							
PHYSICIAN'S NAME (Type) J. E. PYEATTE, LT MC USNR		Patuxent River, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-26-58		22c. NAME OF CEMETERY OR CREMATORIAL Ebenezer Cemetery		22d. LOCATION (City, town, or county) Great Mills, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Station Hospital, U.S.				24a. REC'D BY REGISTRAR DATE APR 30 '58		24b. REGISTRAR'S SIGNATURE D. J. Pyatte	
Naval Air Station, Patuxent River, Md.							

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

## BUREAU V.

APR 30 1958

DE ALERE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4979 CERTIFICATE OF DEATH

Reg. Dist. No.

04976

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>6 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Mechanicsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Lewis</b>	Middle <b>Edward</b>	Last <b>Davis</b>	4. DATE OF DEATH <b>April</b>	Month <b>7</b>	Day <b>19</b>	Year <b>58</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20, 1905</b>	9. AGE (In years last birthday) <b>52</b>	10. IF UNDER 1 YEAR Months <b>5</b>	11. IF UNDER 24 HRS. Days <b>2</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Road</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Davis</b>				14. MOTHER'S MAIDEN NAME <b>Mary Etta Curry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-16-2840</b>		17. INFORMANT <b>Mrs Mabel Dill</b>		Address <b>212 S. Smallwood St. Baltimore, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> INTERVAL BETWEEN ONSET AND DEATH <b>20 mos.</b>							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Myocardial infarction</b> <b>8 months</b>							
DUE TO (c) <b>Coronary artery disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-1</b> , 19 <b>58</b> , to <b>4-7</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4-7</b> , 19 <b>58</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mechanicsville, Md.</b> DATE SIGNED <b>4-8-58</b>							
ACTUAL SIGNATURE <b>David L. Mossman</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					
22b. DATE THEREOF <b>4/10/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Zion</b>		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Albert</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

— 10 —

1000

11282 • J. Neurosci., November 18, 2009 • 29(46):11277–11282

“It is a big country with big problems.”

22.

SODIUM OXIDE

FEBRUARY 1973

P. 100

1000 J. C. WOOLLEY

162 *Environ Biol Fish* (2005) 71

2012-13-2013

2320 *W. J. C. G.*

BUREAU V

APR 10 1959

APR 10 1959  
REF ID: B6514

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be revised by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4980

## CERTIFICATE OF DEATH

04977

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Mutual</b>		d. STREET ADDRESS <b>04X-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Ethel W. Houghton</b>		First	Middle	Last	4. DATE OF DEATH <b>April 26, 1958</b>	Month	Day	Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>August 19, 1919</b>	9. AGE (In years last birthday) <b>38</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			10. AGE (In years last birthday) yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Williams</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Griffin</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-18-0261</b>		17. INFORMANT <b>Barnard I. Smith Leonardtown, Maryland</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.1</b>		DUE TO <i>Ruptured esophageal varices with</i>		INTERVAL BETWEEN ONSET AND DEATH <i>variceal hemorrhage &amp;</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <i>Cirrhosis liver</i>							
DUE TO <i>alcoholism</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Barnard</i>		M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED <b>4/26/58</b>			
PHYSICIAN'S NAME (Type) <b>Michael Babbarich M.D.</b>		Leonardtown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 28, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Christ Church Cem.</b>		22d. LOCATION (City, town, or county) <b>Calvert County, Md.</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G.A. Starkweather &amp; Son - Mutual, Inc.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>APR 29 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Michael</i>			

DEPARTMENT OF HEALTH-ENVIRONMENT

CERTIFICATE OF DESIGN

BUREAU X-5

APR 29 1959

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06118

Reg. Dist. No.

1981

1. PLACE OF DEATH  
a. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Potomac River

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Maryland

b. COUNTY Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Boyd's

15X-2

d. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?

YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First Alice Middle Virginia Last Lawrence

4. DATE  
OF  
DEATH

April

26,

1958

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

Female

White

WIDOWED

DIVORCED

Nov. 29, 1936

9. AGE (In years  
from birth)

21

yrs.

10. IF UNDER 1 YEAR  
Months Days

11. IF UNDER 24 HRS.  
Hours Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John H. Gaver Sr.

14. MOTHER'S MAIDEN NAME

Nellie Catherine Curley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)  
If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

Rufus C. Gilliam

Address

Boyd's, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

850X

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Drowning

INTERVAL BETWEEN  
ONSET AND DEATH  
Immediate

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING  CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Motor boat accident

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20c. TIME OF INJURY Month, Day, Year

3:15 <sup>Hour</sup>  
o. m. April 26, 58

20d. INJURY OCCURRED

While  
at work  Not while  
at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

Potomac River

20f. (City or town)

Off Piney Point, St. Mary's

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and my  
opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

John D. Boyd

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

5/9/58

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

5/13/58

22c. NAME OF CEMETERY OR CREMATORIUM

Barnsville Baptist

22d. LOCATION (City, town, or county)

Barnsville,

Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Hilton Funeral Home Barnsville, Maryland

ADDRESS

24a. REC'D BY REGISTRAR

MAY 13 '58

24b. REGISTRAR'S SIGNATURE

Off Beach



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06119

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute it on a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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18

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4982

PLACE OF DEATH  
a. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Scotland

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Boyd's

Rural

15X-2

d. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?  
YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month  
April

Doy  
26, 1958

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

9. AGE (in years  
last birthday)  
24 yrs.

10. FUNDER 1 YEAR  
Months Days Hours Min.

Male

White

WIDOWED

DIVORCED

June 24, 1933

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Farm

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James David Lawrence

14. MOTHER'S MAIDEN NAME

Lorine Neal

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)  
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

James D. Lawrence Boyd's, Maryland

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

850 X

DUE TO

Conditions, if any, which  
give rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Drowning, accidental

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Motor boat accident

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20c. TIME OF INJURY Month, Day, Year  
Hour o. m.

20d. INJURY OCCURRED  
While  
of work  Not while  
of work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

ST. M.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes  Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

P. J. BEAN

DATE SIGNED

EXAMINER'S  
NAME (Type)

P. J. BEAN, M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

May 24/58

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

5/27/58

22c. NAME OF CEMETERY OR CREMATORI

Barnsville

22d. LOCATION (City, town, or county)

Barnsville

(State)

Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

Hilton Funeral Home Barnsville, Maryland

ADDRESS

24a. REC'D BY REGISTRAR  
MAY 28 '58  
DATE

24b. REGISTRAR'S SIGNATURE  
W. L. Deasey



may be retained by the hospital or attending physician.  
 TO FUNERATOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4983

## CERTIFICATE OF DEATH

04978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 5hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mechanicsville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Richard		First	Middle	Lost	4. DATE OF DEATH April 20, 1958	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1887	9. AGE (In years from last birthday) 70 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 14	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Richard Edward Quade		14. MOTHER'S MAIDEN NAME Betty A. Pilkerton						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Alice R. Quade		Address Oakville, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.5		acute intestinal obstruction				INTERVAL BETWEEN ONSET AND DEATH 1/2 hr		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) undetermined lung pathology						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II if item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Mechanicsville		(County) (State) Md.
21. I certify that I attended the deceased from Sept 4, 1957, to Apr 20, 1958, that I last saw the deceased alive on Apr 20, 1958, and that death occurred at 2 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Leon W. Berube, M.D.						ADDRESS (Street, city or town, state) Mechanicsville, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/23/58		22c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's		22d. LOCATION (City, town, or county) Morganza, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Maryland		24a. REC'D BY REGISTRAR APR 22 '58		24b. REGISTRAR'S SIGNATURE A. F. Redden		

## CERTIFICATE OF DEATH

5756

NAME

NAME

NAME

NAME

NAME

BUREAU Y.

APR 22 1958

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04979

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1984			
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
St. Mary's MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY St. Mary's	
Patuxent River		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
2 years		Naval Air Station, Patuxent River	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?	
Station Hospital, Patuxent River		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Beverley			RANDOLPH
4. DATE OF DEATH		Month	Day
April 4		Year	1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		Caucas.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR
1-20-23		35 yrs.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Naval Aviator		U.S. Navy	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Virginia		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Percy C. Randolph		Jean McNeil Carson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
Yes		Official U.S. Naval Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture, compound, Skull & Evulsion of 860X DUE TO Brain			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
1027 18 a.m. Apr 4 1958		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) USNAS (County) (State)	
		Patuxent River, St. Mary's, Md.	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE J. E. PYEATTE, 1st MC USNR USNAS CHIEF MEDICAL EXAMINER PATUXENT RIVER, MARYLAND DATE SIGNED			
EXAMINER'S NAME (Type) Wm. D. BOYD, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4 April 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		4/17/58	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) (State)	
Old Chapel		Berryville Va.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
W. Clarke Mattingly Leonardtown, Md		DATE APR 25 1958	
		24b. REGISTRAR'S SIGNATURE	
		Albert E. French	

WISCONSIN STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

STATE OF  
WISCONSIN

ES -

DEATH CERTIFICATE

BUREAU V. S.

APR 25 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04980

## 4985 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurry		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Hurry	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First Ernest Middle Destin Last Wheeler			4. DATE OF DEATH Month April Day 27, Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 25 1874	9. AGE (In years old birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Hurry, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Francis Wheeler			14. MOTHER'S MAIDEN NAME Susan Owens		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mary Agnes Wheeler Hurry, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Cardiac decompensation Arteriosclerotic CV disease 10 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 19, 1958, to April 27, 1958, that I last saw the deceased alive on Feb 19, 1958, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Md DATE SIGNED 4/28/58					
ACTUAL SIGNATURE <i>Ernest Wheeler</i>		M.D.			
PHYSICIAN'S NAME (Type) Burial		22c. NAME OF CEMETERY OR CREMATORIALy Sacred Heart		22d. LOCATION (City, town, or county) Bushwood, (State) Maryland	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF 4/30/58		24e. REC'D BY REGISTRAR DATE APR 30 '58	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland			24f. REGISTRAR'S SIGNATURE <i>W. Clarke Mattingley</i>		

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APR 30 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be re-  
 by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the funeral director.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**4986 CERTIFICATE OF DEATH**

Reg. Dist. No. **04981**

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>35 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>James Dudley Wood</b>			First	Middle	Last
4. DATE OF DEATH <b>April 5 1958</b>			Month	Day	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>Oct. 24 1903</b>	9. AGE (In years lost birthday) <b>54 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>George William Wood</b>			14. MOTHER'S MAIDEN NAME <b>Molly Wahlen</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>			16. SOCIAL SECURITY NO. <b>214-20-3050</b>	17. INFORMANT <b>Grace T. Wood</b>	Address <b>Lexington Park, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>—</b>	(County) (State) <b>—</b>
21. I certify that I attended the deceased from <b>3/5</b> , 1958, to <b>4/5</b> , 1958, that I last saw the deceased alive on <b>4/5</b> , 1958, and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <b>Lexington Park, Md.</b> DATE SIGNED <b>—</b>					
ACTUAL SIGNATURE <b>Julian Lane M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/7/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Andrews</b>	22d. LOCATION (City, town, or county) (State) <b>Leonardtown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley, Leonardtown, Md.</b>			ADDRESS	24a. REC'D BY REGISTRAR <b>APR 9 '58</b>	24b. REGISTRAR'S SIGNATURE <b>John Heath</b>

WISCONSIN STATE DEPARTMENT OF HEALTH - SERVICE 70

CERTIFICATE OF DEATH

BUREAU V. 8

APR 9 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4987

Item 8 Film 0228 5-15-58 et

## CERTIFICATE OF DEATH

04982

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood		c. LENGTH OF STAY IN 1b 34 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Thaddeus	Middle Yates	4. DATE OF DEATH April 30, 1958	Month April	Day 30	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1865 Aug. 20, 1866	9. AGE (In years lost birthday) 92 yrs.	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Days 10	Hours Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Martin Hayden Yates				14. MOTHER'S MAIDEN NAME Mary Alice Ford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 216-38-6179		17. INFORMANT Mrs Florence B. Yates		Address Hollywood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X DUE TO Pneumonia						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Cardiac failure							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Age						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 20, 1958</u> to <u>April 30, 1958</u> , that I last saw the deceased alive on <u>April 30, 1958</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Charles Greenwell M.D.</u>				ADDRESS (Street, city or town, state) <u>Leonardtown, Md.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) Charles Greenwell M.D.				Leonardtown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/3/58		22c. NAME OF CEMETERY OR CREMATORIAL St. Aloysius		22d. LOCATION (City, town, or county) (State) Leonardtown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Maryland		24a. REC'D BY REGISTRAR DATE MAY 5 '58		24b. REGISTRAR'S SIGNATURE O. L. Smith	

ER ANOMALIES—HIGHLIGHTS FROM THE STATE CHARTER